CSR Reconciliation Issuer to MIDAS Inbound Specification

Publication: January 5, 2017
Version: 2.0

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ITC-ICSRRL0

CSR Reconciliation Inbound Specification

The purpose of this document is to provide the details on cost-sharing reduction (CSR) reconciliation files that will be received in the Multidimensional Insurance Data Analytics System (MIDAS). This specification document (version 2.0) is applicable to CSR reconciliation for the 2016 benefit year as well as restatements for prior benefit years. The issuer will need to submit files to MIDAS in pipe delimited format. The file format that will be used is ASCII text and will use a CRLF as the line terminator. The file submitted by the issuers should have only ONE HIOS identifier. If the issuer is submitting data for multiple HIOS IDs, for example as the result of an acquisition, the issuer must create a separate file for each HIOS ID. The function code for this submission will be CSRI.

CSR Reconciliation Submission Files:

The filenames proposed for usage by issuers will consist of the following sections:

1. Trading Partner (TP) Identifier (ID)
2. Application ID
3. Function Code
4. Date
5. Time
6. Environment Code
7. Direction

Trading Partner (TP) Identifier (ID):

TPID is the identification number assigned to the Trading Partner. The length of the TPID can range between 5-10 characters. The TPID that should be used for CSR Reconciliation must be the same as that has been used for 820 payments with function code F820.

Application ID:

The Application ID section of the filename is an ID for the application that processes the files. This section specifies the target application where the system routes the file. This is a static value and is MID for this process.

Function Code:

The Function Code section of the filename is an alphanumeric code indicating the functional purpose of the file within the application. This also helps identify specific processing once the system routes the file to the application. This is a static value and is CSRI for all the data.

Date:

The Date section of the filename specifies the date the issuer transferred the file in **D**YYMMDD format. The first **D** is static text.

Time:

The Time section of the filename specifies the time created (timestamp) for the file in **T**HHMMSSmmm format where HH is hours, MM is minutes, SS is seconds, and mmm is milliseconds. The **T** is static text and exactly nine numerals must follow.

Environment Code:

The Environment Code section of the filename is a single character code indicating the environment to which the system transfers the file. Allowed values are as follows:

☐**P** for Production Environment (PROD)

☐**T** for Test Environment (TEST) and Implementation Environment (IMP)

Note: No file with a .T extension should include real production data. This filename is reserved for dummy/test data only, and cannot be used during the open submission window.

Direction:

The Direction section of the filename indicates the direction in which the data flows, towards the Centers for Medicare & Medicaid Services (CMS) or away from CMS:

☐**IN** for to CMS
☐**OUT** for from CMS

All the sections need to be separated by a period (.)

Example of a sample filename: **12345678.MID.CSRI.D160501.T123136760.P.IN**

Data Files Overview

Data files are created by HIOS ID and these files should never be zipped.

ID	Name	Min Use	Max Use
01 Issuer Summary Record	ITC-ICSRRL0-Record ID	1	1
02 Plan Summary Record	ITC-ICSRRL0-Record ID	0	N/A
03 Policy Detail Record	ITC-ICSRRL0-Record ID	1	N/A

01 Issuer Summary Record

ITC-ICSRRL0-Record Id **Min Use: 1** **Max Use: 1**
Grp: **Fields: 27**

Issuer Summary Information: Issuer identification, data extraction time and date, methodology, acquisition information, and aggregate amount of actual CSR provided for all QHPs under this issuer.

Pos	ID	FIELD	Type	Min Len	Max Len	Req
01	**101**	**Record-Code** **Purpose:** Record Code – Always 01 for Issuer Summary Information.	Text	2	2	Mandatory
02	**102**	**Trading Partner ID** **Purpose:** The Trading Partner number assigned.	Text	5	10	Mandatory
03	**103**	**Issuer State Code** **Purpose:** Enter the 2-letter state code for issuer's state of licensure.	Text	2	2	Mandatory
04	**104**	**HIOS ID** **Purpose:** The five-digit Health Insurance Oversight System (HIOS)–generated Issuer ID number.	Numeric	5	5	Mandatory
05	**105**	**Issuer Extract Date** **Purpose:** Date information extracted by the issuer from the issuer's data base. Note: Valid date format is MMDDYYYY.	Numeric	8	8	Mandatory
06	**106**	**Issuer Extract Time** **Purpose:** Time information extracted by issuer from the issuer's data base. Note: Valid format is HHMMSS- (Hour, Minutes, and Seconds).	Numeric	8	8	Mandatory
07	**107**	**Benefit Year** **Purpose:** Date information extracted by the issuer from the issuer's data base. For restatements, enter benefit year 2015. Note: Valid format is YYYY. The values should be restricted to 2015 or 2016.	Numeric	4	4	Mandatory
08	**108**	**Total Actual CSR Amount** **Purpose:** Total CSR amount provided by this QHP issuer to enrollees in all CSR eligible policies. For restatement files, this is the CSR amount provided by this QHP issuer to enrollees in all (03) Policy Detail Records, including restated policies and policies that are not being restated. **Note**: Maximum value is 999999999.99 with an explicit decimal. If not available then initialize to "0.00". The precision is restricted to 2 decimal points.	Numeric	4	12	Mandatory
09	109	**Total CSR Amount Advanced to the Issuer by CMS** **Purpose:** Amount the issuer shows received from CMS for the benefit year January 1 to December 31. Issuers should include adjustments to advance payments for the applicable benefit year that were received by the closeout of advance payments in the April 2017 payment cycle. For restatement files, the issuer should report the total amount of advance payments for the applicable benefit year as of the closeout payment cycle for that benefit year (this amount	Numeric	4	12	Optional

should match the original data file.)

Note: Maximum value is 999999999.99 with an explicit decimal. If not available then initialize to "0.00". The precision is restricted to 2 decimal points.

10	**110**	**Reconciliation Methodology**	Text	8	13	Mandatory

Purpose: Indicates the Reconciliation methodology used and the valid values are – STANDARD, SIMPLIFIED or SIMPLIFIED AV. Issuers using the AV method exclusively must select the SIMPLIFIED AV method.

11	**111**	**Acquisition**	Text	1	1	Mandatory

Purpose: Has the issuer HIOS ID filing this reconciliation report been acquired by another issuer in the applicable benefit year? Valid values are Y or N.

Note: This field value is case insensitive.

12	**112**	**Acquisition Effective Dates**	Date	0	8	Conditional

Purpose: Date the acquisition was final. Value is required if the Acquisition is set to Y.

Note: The valid date format is MMDDYYYY.

13	**113**	**Acquiring Issuer**	Text	5	5	Conditional

Purpose: HIOS ID of the acquiring issuer. Value is required if the Acquisition is set to Y.

14	**114**	**Merger**	Text	1	1	Mandatory

Purpose: Has the issuer (HIOS ID) filing this reconciliation report merged with or absorbed another issuer in the applicable benefit year? Valid values are Y or N.

Note: This field value is case insensitive.

15	**115**	**Merger Issuer**	Text	0	5	Conditional

Purpose: List the HIOS ID of the other issuer(s) party in the merger. Value is required if the Merger is set to Y.

16	**116**	**Merger Effective Dates**	Date	0	8	Conditional

Purpose: Date the merger was final. Value is required if the Merger is set to Y.

Note: Valid date format is MMDDYYYY.

17	**117**	**Technical POC First Name**	Text	2	100	Mandatory

Purpose: To identify the first name of the technical POC of the issuer.

18	**118**	**Technical POC Last Name**	Text	2	100	Mandatory

Purpose: To identify the last name of the technical POC of the issuer.

19	**119**	**Technical POC Email Address**	Text	2	100	Mandatory

Purpose: To identify the email address of the technical POC of the issuer.

20	**120**	**Technical POC Organization Title**	Text	2	100	Mandatory

Purpose: To identify the organization of the technical POC of the issuer.

21	**121**	**Technical POC Phone Number**	Numeric	10	10	Mandatory

Purpose: To identify the phone number of the technical POC of the issuer.

22	**122**	**Business POC First Name**	Text	2	100	Mandatory
		Purpose: To identify the first name of the business POC of the issuer.				
23	**123**	**Business POC Last Name**	Text	2	100	Mandatory
		Purpose: To identify the last name of the business POC of the issuer.				
24	**124**	**Business POC Email Address**	Text	2	100	Mandatory
		Purpose: To identify the email address of the business POC of the issuer.				
25	**125**	**Business POC Organization Title**	Text	2	100	Mandatory
		Purpose: To identify the organization of the business POC of the issuer.				
26	1**26**	**Business POC Phone Number**	Numeric	10	100	Mandatory
		Purpose: To identify the phone number of the business POC of the issuer.				
27	**127**	**Total Number of CSR Variant Plans under this HIOS ID**	Numeric	1	100	Mandatory
		Purpose: Total count of CSR plan variations for this QHP issuer. Include plan variations with enrollment only, whether or not cost-sharing reductions were provided.				
28	**128**	**Total Number of Exchange-assigned Subscriber IDs in all CSR Variant Plans under this HIOS ID**	Numeric	1	100	Mandatory
		Purpose: Total count of Exchange-assigned Subscriber IDs associated with a (03) Policy Detail Record in all plan variations for this QHP issuer. For restatement files, this is the total number of (03) Policy Detail Records, including restated policies and policies that are not being restated.				

02 Plan Summary Record (Optional)

ITC-ICSRRL0-Record Id **Min Use: 0** **Max Use: N/A**
Grp: **Fields: 9**

Plan Summary Record: Issuers will send plan-related data elements for all QHPS, including allowed costs for EHB claims, amounts paid by the issuer and policy holder, amount the policy holder would pay under the standard plan, and actual CSR provided. Only submit reports for plans with enrollment.

Pos	ID	FIELD	Type	Min Len	Max Len	Req
01	**201**	**Record-Code**	Text	2	2	Mandatory
		Purpose: Record type to indicate that this refers to the Plan details. Note: Should always be 02 for Plan Summary Record.				
02	**202**	**QHP ID**	Text	16	16	Mandatory
		Purpose: Enter the 16-digit HIOS-generated qualified health plan identification number. This includes the 14-digit standard plan ID plus the 2-digit variant ID.				
03	**203**	**Total Annual Premium**	Numeric	4	12	Optional
		Purpose: Aggregate billed premium for this plan for the applicable benefit year Note: This is the Total Premium Amount. Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points				
04	**204**	**Total Allowed Costs for EHB**	Numeric	4	12	Mandatory
		Purpose: Aggregate total allowed costs (including restated total allowed costs, if submitted as part of a restatement file) for essential health benefits for all enrollees in this plan. Issuers including issuers of capitated plans may use plan-specific percentage estimates of non-EHB claims submitted on the Unified Rate Review Template or any other reasonable method to determine total allowed costs for EHB. Note: This is the Total allowed costs for EHB. Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points				
05	**205**	**Total Actual Amount the Issuer Paid for EHB**	Numeric	4	12	Mandatory
		Purpose: The amount (including restated amount, if submitted as part of a restatement file) the issuer paid providers for EHB for all services to enrollees in this plan. This includes cost-sharing reduction reimbursement amounts to fee-for-service providers to the extent the issuer reimbursed fee-for-service providers. Issuers that provide for essential health benefits on a partially or fully capitated basis should enter all amounts paid by the issuer for those services. This value does not include enrollee liability. Note: This is the total actual amount the issuer paid for EHB. Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.				
06	**206**	**Total Actual Amount Paid For EHB by Enrollees**	Numeric	4	12	Mandatory
		Purpose: Total amount (including the restated amount, if submitted as part of a restatement file) all enrollees in this plan paid (or are liable for) in cost sharing for all EHB services. Note: This is the Total actual amount paid for EHB by enrollees. Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.				

07	**207**	**Total actual amount for EHB enrollees would have paid in the standard plan**	Numeric	4	12	Mandatory

Purpose: The amount (including the restated amount, if submitted as part of a restatement file) the enrollee(s) would have paid for the same claims had he/she/they been enrolled in the standard plan without cost-sharing reductions. For the standard methodology, dollar amounts entered here must be calculated in accordance with HHS guidance on re-adjudication of claims.

Note: This is the total actual amount for EHB enrollees would have paid in the standard plan. Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

08	**208**	**Total actual value of CSR Provided**	Numeric	4	12	Mandatory

Purpose: The total amount (including the restated total amount, if submitted as part of a restatement file) all enrollees would have paid under the standard plan, minus the amount the enrollees did pay under the plan variation (and reimbursed to fee-for-service providers, if applicable.) .

Note: This is the Total Actual value of CSR provided. Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points. Negative amounts are permitted solely for reporting purposes.

09	**209**	**Total number of Exchange Subscriber IDs in this plan variation for the benefit year**	Numeric	1	100	Mandatory

Purpose: Total count of Exchange subscriber IDs enrolled in this plan variation at any point during the benefit year.

03 Policy Detail Record

ITC-ICSRRL0-Record Id **Min Use: 1** **Max Use: N/A**
Grp: **Fields: 14**

Policy Detail Information: Issuers will send policy related data elements for all QHPs, including Exchange-assigned Subscriber ID, EHB amounts, amounts the issuer and enrollee paid, and actual CSR provided.

Pos	ID	FIELD	Type	Min Len	Max Len	Req
01	**301**	**Record-Code**	Text	2	2	Mandatory
		Purpose: Record code to indicate that this refers to the Policy details. Note: Should always be 03 for Policy Detail Records.				
02	**302**	**Exchange-assigned Subscriber ID**	Text	10	10	Mandatory
		Purpose: The subscriber identification number assigned by the Exchange. Issuers should list the State Based Exchange-assigned Subscriber ID if applicable.				
03	**303**	**Exchange -assigned Policy ID**				Optional
		Purpose: The Policy ID Assigned by the Exchange for the policy for which CSR amounts are being reported**.** If this is an aggregated policy record, report the current Policy ID Number.				
04	**304**	**Exchange-assigned Policy Start Date**	Date	8	8	Optional
		Purpose: The Policy ID start date. First date the subscriber enrolled in this policy. This is the start date for the current Policy ID and may be different from the plan start date for this subscriber.				
05	**305**	**Exchange-assigned Policy End Date**	Date	8	8	Optional
		Purpose: The Policy ID end date. Last date the subscriber was enrolled in this policy.				
06	**306**	**QHP Plan ID**	Text	16	16	Mandatory
		Purpose: Enter the 16 digit HIOS generated qualified health plan identification number. This includes the 14 digit standard plan ID plus the 2 digit variant ID.				
07	**307**	**Plan Benefit Start Date**	Date	8	8	Mandatory
		Purpose: First date the subscriber was enrolled in this plan variation. If the issuer is filing more than one policy record for this subscriber, the start date may be different from the Policy Start Date. Note: Format is MMDDYYYY.				
08	**308**	**Plan Benefit End Date**	Date	8	8	Mandatory
		Purpose: Last date the subscriber was enrolled in this plan variation. Note: Format is MMDDYYYY.				
09	**309**	**Total Monthly Premium**	Numeric	4	12	Optional
		Purpose: The monthly premium amount for this policy for the applicable benefit year. If the policy changed to self-only or other than self-only during the benefit year, or if the monthly premium amount changed during the applicable benefit period as the result of other circumstances, enter the average monthly premium for this policy over the months in which it was in effect. Note: This is the Total Premium Amount. Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.				

10	**310**	**Self Only/Other than self-only**	Text	1	1	Conditional

Purpose: For the Simplified methodology and Simplified Actuarial Value only, report whether coverage under this policy is self only, or other than self-only.
Note: Required only if the methodology is SIMPLIFIED or SIMPLIFIED AV.
Valid values are Self (S) or Other (O).

11	**311**	**Annual limitation on cost Sharing for the standard Plan**	Numeric	4	12	Conditional

Purpose: This is the annual limitation on cost sharing for the standard plan associated with this plan variation as reported to CMS for plan certification for the applicable benefit year. If the policy is self-only, the annual limitation is the self-only annual limitation. Value is required for Simplified and Simplified actuarial value methodology only.

Note: Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

12	**312**	**Actuarial value amount of the Standard plan**	Numeric	4	12	Conditional

Purpose: This is the actuarial value of the standard plan associated with this plan variation as reported to CMS for plan certification for the applicable benefit year. Required for the simplified actuarial value methodology only.

Note: Required only for Simplified AV methodology. Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column.

13	**313**	**Total allowed costs for EHB**	Numeric	4	12	Mandatory

Purpose: Total allowed costs (including restated total allowed costs, if submitted as part of a restatement file) for essential health benefits incurred by the enrollee(s) on this policy. Issuers including issuers of capitated plans may use plan-specific percentage estimates of non-EHB claims submitted on the Unified Rate Review Template or any other reasonable method to determine total allowed costs for EHB. Total allowed costs in the cost-sharing reduction plan variation must be the same as those in the associated standard plan.

Note: Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points

14	**314**	**Actual amount the issuer paid for EHB**	Numeric	4	12	Mandatory

Purpose: This is the total dollar amount (including the restated total dollar amount, if submitted as part of a restatement file) the issuer paid to providers for all EHB services to enrollees on this policy. This includes cost-sharing reduction reimbursement amounts to fee-for-service providers to the extent the issuer reimbursed fee-for-service providers. Issuers that provide for essential health benefits on a partially or fully capitated basis should enter all amounts paid by the issuer for those services. This value does not include enrollee liability.

Note: Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

15	**315**	**Actual amount the enrollee(s) paid for EHB**	Numeric	4	12	Mandatory

Purpose: The amount (including the restated amount, if submitted as part of a restatement file) all enrollees on this policy paid (or are liable for) in cost sharing for all EHB services.

Note: Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

16	**316**	**Actual amount the enrollee(s) would have paid under the standard plan**	Numeric	4	12	Mandatory

Purpose: The amount (including the restated amount, if submitted as part of a restatement file) the enrollee(s) would have paid for the same EHB claims had he/she/they been enrolled in the standard plan without cost-sharing reductions.

Note: Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points.

17	**317**	**Actual CSR Provided**	Numeric	4	12	Mandatory

Purpose: The CSR Provided amount is the amount (including the restated amount, if submitted as part of a restatement file) enrollees would have paid under the standard plan, minus the amount the enrollees did pay under the applicable plan variation (and reimbursed to fee-for-service providers, if applicable.).

Note: Maximum value is 999999999.99, with an explicit decimal point. If not available then initialize to "0.00". No commas should be used in this column. The precision is restricted to 2 decimal points. If the standard plan cost sharing is less than the cost-sharing reduction amount provided, enter a negative number.

CSR Reconciliation Business Validations for Issuer, Plan and Summary

Note: Business validations are separate from format validations. Issuers may receive format validation errors if data elements do not meet the format requirements defined above. Refer to the error code list for a complete list of possible error codes.

Business Validations for Data Elements in Issuer Summary Records (01)

ID #	Element Name	Business Validation	CMS Action if Validation Fails
1.	Record-Code	Values equal "01"	CMS will reject the file.
2.	Trading ID	Validate the TPID and HIOSID association using FEPS reference data.	CMS will reject the file.
3.	Issuer State Code	N/A	N/A
4.	HIOS ID	Validate the existence of HIOS ID in the FEPS Master Reference issuer list based on the benefit year.	CMS will reject the file.
5.	Issuer Extract Date	N/A	N/A
6.	Issuer Extract Time	N/A	N/A
7.	Benefit Year	Benefit Year will be 2015 or 2016.	CMS will reject the file.

8.	Total Actual CSR Amount	The TOTAL ACTUAL CSR AMOUNT at the issuer level must match the sum of all CSR PROVIDED at the policy level.	CMS will accept and process the file, but send an error.
9.	Total CSR Amount Advanced To The Issuer By CMS	N/A	N/A
10.	Reconciliation Methodology	The methodologies that are accepted are STANDARD, SIMPLIFIED, SIMPLIFIED AV. These fields are not case sensitive.	CMS will reject the file.
11.	Acquisition	The accepted values for this field are Y and N. These fields are not case sensitive.	CMS will accept and process the file, but send an error.
12.	Acquisition Effective Dates	Acquisition Effective Date is required if there was an Acquisition (Acquisition set to Y).	CMS will accept and process the file, but send an error.
13.	Acquiring Issuer	Issuers should list HIOS ID of the acquiring issuer. It is required if there was an Acquisition (Acquisition set to Y).	CMS will accept and process the file, but send an error.
14.	Merger	The accepted values for this field are Y and N.	CMS will accept and process the file, but send an error.
15.	Merger Issuer	Merger Issuers should be on the list of HIOS ID's that have been merged. It is required if there was a Merger (Merger set to Y).	CMS will accept and process the file, but send an error.
16.	Merger Effective Dates	Merger Effective Date is required if there was a Merger (Merger set to Y).	CMS will accept and process the file, but send an error.
17.	Technical POC First Name	N/A	N/A
18.	Technical POC Last Name	N/A	N/A
19.	Technical POC Email Address	N/A	N/A

20.	Technical POC Organization Title	N/A	N/A
21.	Technical POC Phone Number	N/A	N/A
22.	Business POC First Name	N/A	N/A
23.	Business POC Last Name	N/A	N/A
24.	Business POC Email Address	N/A	N/A
25.	Business POC Organization Title	N/A	N/A
26.	Business POC Phone Number	N/A	N/A
27.	Total Number Of CSR Variant Plans Per HIOS ID	The total number of plans submitted at the (03) Policy Detail Record should match the number of CSR variant plans per HIOS ID.	CMS will reject the file.
28.	Total Number of Exchange-assigned Subscriber IDs under this HIOS ID	The count of the number of Exchange-assigned Subscriber IDs in the (03) Policy Detail Records.	CMS will reject the file.

Business Validations for Data Elements in (03) Policy Detail Records

ID #	Element Name	Business Validation	CMS Action if Validation Fails
1.	Record-Code	Values equal “03”	CMS will reject the file.
2.	Exchange-assigned Subscriber Id	Validate against the FEPS enrollment data for Individual market places only. The values will be validated for FFM plans only.	CMS will accept and process the file, but send an error. Note: If less than 50% of (03) Policy Detail Records have a valid Exchange-assigned Subscriber Id, CMS will reject the file.
3.	Exchange-assigned Policy ID	N/A	N/A

ID #	Element Name	Business Validation	CMS Action if Validation Fails
4.	Exchange-assigned Policy Start Date	N/A	N/A
5.	Exchange-assigned Policy End Date.	N/A	N/A
6.	QHP ID	QHP ID should be a valid 16-digit HIOS ID plan identifier provided by the issuer for a specific coverage year.	CMS will reject the file.
7.	Plan Benefit Start Date	N/A	N/A
8.	Plan Benefit End Date	N/A	N/A
9.	Total Monthly Premium	N/A	N/A
10.	Self /Other	Input is required if the issuer elected Simplified method or Simplified AV as their Reconciliation Methodology. The values entered must be S or O.	CMS will accept and process the file, but send an error.
11.	Annual Limitation On Cost Sharing For The Standard Plan	Input is required if the issuer elected Simplified or Simplified Actuarial Value method as their Reconciliation Methodology.	CMS will accept and process the file, but send an error.
12.	Actuarial Value of the Standard Plan	Input is required if the issuer elected Simplified AV method as their Reconciliation Methodology.	CMS will accept and process the file, but send an error.
13.	Total Allowed Costs For EHB	N/A	N/A
14.	Amount the Issuer Paid	N/A	N/A
15.	Amount the Enrollee(s) Paid	N/A	N/A

ID #	Element Name	Business Validation	CMS Action if Validation Fails
16.	Amount the enrollee(s) would have paid under the standard plan	N/A	N/A
17.	CSR provided	The CSR PROVIDED is the amount the enrollee(s) would have paid under the standard plan less the amount the enrollee(s) paid. The tolerance threshold for payment amount validation is less than $1.	CMS will reject the file.

Appendix A

1.1 Enterprise File Transfer (EFT) Location

CMS will only accept submissions through EFT.

For direct SFTP (for automation) - sftp://eft.feps.cms.gov

- When using SFTP, send files using the "Inbound 30" folder.

The folder structure is applicable to both test and production. Differentiation is based on the .T or .P within the file name. **Note**: No file with a .T extension should include real production data. This filename is reserved for dummy/test data only.

1.2 Error handling

If the data submitted fails any of the business validations (see tables above), an error report will be generated, the issuer will receive an email indicating that the file has been submitted with errors, and the CSR Reconciliation Outreach Team will be notified. The file will be rejected when mandatory data elements are not included or are input incorrectly, and the issuer will receive an email indicating that the file has been rejected and cannot be processed. A comprehensive error report will be generated and will be sent to the issuer's outbound folder through the EFT. Every issuer will get a summary report for all processing statuses, including successful submission without errors.

Refer to the business validation tables on Pages 12-16 for CMS processing responses to files based on field validations.

1.3 Resubmission Process

1.3.1 Resubmissions by Issuers

CMS will consider every resubmission as a new submission. The name of the file must be unique. Every resubmission by issuers must have a new date and time. CMS will not accept or process resubmissions with identical dates and times in the file name. Each time an issuer resubmits, it must submit the entire file (i.e. the full pipe-delimited file). Because CMS will not process partial resubmissions, issuers should plan accordingly by saving their flat, pipe-delimited file in a separate environment so that it can be modified and resubmitted as necessary.

1.3.2 CSR Outreach Team

An outreach team is being formed to facilitate the accurate and timely submissions of files from the issuers to CMS. The outreach team will provide coordination between CMS and contract partners. The files submitted by issuers and the files' statuses are communicated across stakeholders to identify any issues/errors in file submission to be resolved by issuers. Tracking and reporting the success or failure of each issuer's file by submission month will occur on a daily basis. The outreach team can be reached for questions and assistance at CSRreconquestions@cms.hhs.gov.

Appendix B

Email Messages to Issuers Regarding Status of Files

Scenario	Status	Email Message/Error Message
CMS has accepted and processed the issuer's file submission but still needs to confirm that attestation forms have been received and processed successfully. The data submission passed all CMS validations. Note: The issuer will not receive any validation errors in the scenario where they have submitted a file but have not submitted data specifically for one or more QHP IDs, so issuers should review the summary report in the EFT to determine if CMS has identified any QHP IDs for which data is missing.	Accepted and Processed	CMS has processed your CSR reconciliation file submission. Your submission passed all CMS validation checks. Your data submission will be marked as complete contingent on your attestation(s) submission being accepted and processed successfully. You will receive a summary report in your EFT folder within the next 24 hours that includes your CSR reconciliation amount, which was calculated based on the data you have submitted to date. Please review the report. It will include any QHP IDs for which you have not submitted data, if applicable.
CMS has received and processed the issuer's data file submission, but the file has errors.	FILE ACCEPTED BUT WITH ERRORS	CMS has processed your CSR reconciliation file submission, but the file has errors. You will receive an error report in your EFT folder within the next 24 hours that summarizes the errors. Review the error report to determine if you need to correct the data, in which case you should resubmit the entire file to CMS. Additionally, the report includes your CSR reconciliation amount, which was calculated based on the data you have submitted to date. The report will also include any QHP IDs for which you have not submitted data, if applicable.

CMS has rejected the issuer's file submission due to data formatting or other critical error(s).	FILE REJECTED	CMS has rejected your CSR reconciliation file submission due to formatting or other critical errors. You will receive an error report in your EFT folder within the next 24 hours that summarizes the errors. Review the error report to determine what you need to correct, and then resubmit the entire file to CMS. All data resubmissions must include the required attestations in order for your submission to be considered complete.
Attestation form(s) has been accepted.	ATTESTATION FORM(S) ACCEPTED AND PROCESSED SUCCESSFULLY	CMS has received your CSR reconciliation attestation form(s) and it has been processed successfully. Your form(s) passed CMS's validation checks. Your submission will be marked as complete contingent on your data file being submitted and processed successfully.
Attestation form(s) has been rejected and need to be resubmitted	ATTESTATION FORM(S) HAS BEEN REJECTED	CMS rejected your attestation form(s) because it failed the validation process. Your attestation form(s) needs to be corrected and resubmitted. Below is a summary of the errors associated with your attestation form(s). Review the errors to determine what corrections need to be made, and then resubmit a corrected form(s).
Email Reminder	REMINDER EMAIL TO ISSUERS WHO HAVE NOT SUBMITTED DATA/ATTESTATION FILES	CMS has not received your CSR reconciliation file and/or attestation form(s). The due date for submission is June 2, 2017 at 11:59 p.m. Eastern Standard Time (if the deadline falls on a Saturday or Sunday, you have until 11:59 p.m. Eastern Standard Time the following Monday to provide the submission to CMS).